South Central Missouri Community Health Center
DBA Your Community Health Center
1081 East 18th Street
Rolla, MO 65401
573-426-4455
Fax 855-507-9273

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT RECEIPT

I have received on this visit/admission or previous one, the Notice of Privacy Practices that explains how the facility may use my information. The Notice of Privacy Practices is also available on Your Community Health Center website. As explained in the Notice of Privacy Practices, Your Community Health Center will only obtain my written authorization to release information about me if it is not permitted or required by law to disclose this information without authorization

First Name MI Last Name DOB

PATIENT RECORDS OR DISCLOSERS

IN GENERAL, THE HIPPA PRIVACY RULE GIVES INDIVIDUALS THE RIGH TO REQUEST RESTRICTION ON DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION (PHI). THE INDIVIDUAL IS ALSO PROVIDED THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OR THAT A COMMUNICATION OF PHI MAY BE MADE BY ALTERNATE MEANS SUCH AS: SENDING CORRESPONDENCE TO THE INDIVIDUALS OFFICE OR CELL PHONE, INSTEAD OF INDIVIDUALS HOME PHONE.

I give consent to Your Community Health Center to release/discuss details of my medical care, including test results, medications, appointments, and other information with the persons listed below:

NAME	RELATIONSHIP	PHONE NUMBER

☐ I authorize and give my consent for Your Community Health Center to text appointment information, reminders and clinic information to the following phone number
_____.

☐ I authorize and give my consent for Your Community Health Center to email appointment information, reminders and clinic information to the following email.
_____.

Signature of Patient/Parent or Legal Guardian Date